DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF HEALTH
(HEALTH BENEFITS PLAN MEMBERS' BILL OF RIGHTS PROGRAM)
REPORTING FORM
(D.C. CODE 44-301.10, 2001 Edition)

REPORTING PERIOD:_____ **NAIC#:**_____

Months Reported: _____
Company Name: _____
Mailing Address: _____
_____

PLEASE PROVIDE THE FOLLOWING INFORMATION ON THE PERSON RESPONSIBLE FOR PROVIDING THIS GRIEVANCE INFORMATION:

Staff Contact: _____
Staff Title: _____
Mailing Address: _____
_____
_____
Staff Phone: _____
Staff Fax: _____
Staff Email Address: _____

IMPORTANT

IF YOUR COMPANY HAS NO GRIEVANCES TO REPORT FOR THIS FILING PERIOD, AND/OR IS EXEMPT FROM FILING A REPORT WITH THE DISTRICT OF COLUMBIA, DEPARTMENT OF HEALTH, PLEASE RESPOND AS APPROPRIATE, ATTACH APPROPRIATE DOCUMENTS, DATE AND SIGN BELOW AND RETURN ONLY THIS FIRST PAGE OF THE FORM AND DOCUMENTS TO THE ADDRESS BELOW:

_____ Our Company has **NO GRIEVANCES** to report for this filing period.

_____ Our Company is exempt from filing a Report of Grievances. Documentation granting this exemption is attached.

AUTHORIZED SIGNATURE:_____ **DATE:**_____

TITLE:_____ **PHONE:**_____

RETURN TO:

Grievance and Appeals Coordinator
District of Columbia Department of Health
825 North Capitol Street, N.E., room 4119
Washington, D.C. 20002
Phone: (202) 442-5979 **Fax: (202) 442-4797** **Email: Patrick2.Kelly@dc.gov**

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REPORTING PERIOD:_____ NAIC#:_____

1. **Please provide the aggregate number of grievances filed (and resolved) with your company during the period for which you are reporting.**

TOTAL GRIEVANCES:_____

2. **Please breakdown the aggregate number provided in your answer to Question 1 into the following categories:**

	DESCRIPTION	TOTAL	UPHELD	OVER-TURNED	PARTIAL OVERTURN
A	Inpatient Hospital Services				
B	Emergency Room Services				
C	Mental Health Services				
D	Physician Services				
E	Laboratory, Radiology Services				
F	Pharmacy Services				
G	PT, OT, ST Services (including Inpatient rehabilitation service)*				
H	Skilled Nursing, Sub-Acute Facility, Nursing Home Services				
I	Durable Medical Equipment				
J	Podiatry Services				
K	Dental Services				
L	Optometry Services				
M	Chiropractic Services				
N	Home Health Services				
O	Other				
	TOTAL				

***Inpatient Acute Rehabilitation Services are reported with Inpatient Acute Hospital Services since acute rehabilitation and acute inpatient admissions are part of the same reportable benefit structure.**

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For each category identified in Question 2, please list five most common procedures/services/items that were at issue in the grievances and the final disposition as requested below:

GRIEVANCE BY SPECIFIC ICD-9 CODE AND DESCRIPTION

	ICD-9 CODE AND DESCRIPTION	TOTAL	UPHELD	OVER-TURNED	PARTIAL
A					
A					
A					
A					
A					
B					
B					
B					
B					
B					
C					
C					
C					
C					
C					
D					
D					
D					
D					
D					
E					
E					
E					
E					
E					
F					
F					
F					
F					
G					
H					
I					
J					
K					

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3. **Please provide the aggregate number of grievances filed and resolved by your company during this reporting period that involved a Hospital Length of Stay/Denial of Hospital Days:**

   Aggregate number of grievances involving a Hospital Length of Stay/Denial of Hospital Days:_____

   Please breakdown the aggregate number of grievances in your answer to Question 3 into the following categories:

GRIEVANCES INVOLVING HOSPITAL LENGTH OF STAY/DENIAL OF DAYS

ICD-9 CODE AND DESCRIPTION	TOTAL	UPHELD	OVER-TURNED	PARTIAL OVERTURN
TOTAL				

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REPORTING PERIOD:_____ NAIC#:_____

4. **Please provide the aggregate number of grievances filed and resolved by your company during this period that were considered EMERGENCY/EXPEDITED CASES:**

   Aggregate number of grievances that were considered Emergency/Expedited Cases:_____

   Please breakdown the aggregate number of grievances in your answer to Question 4 into the following categories:

GRIEVANCES INVOLVING EMERGENCY/EXPEDITED CASES

ICD-9 CODE AND DESCRIPTION	TOTAL	UPHELD	OVER-TURNED	PARTIAL OVERTURN
TOTAL				

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REPORTING PERIOD:_____ **NAIC#:**_____

5. **Statistical Time for Resolution: For both grievances considered to be emergency cases and those that were not emergency cases, please provide the average time within which your company made a grievance decision. For non-emergency cases, please express time in calendar days only.**

   Resolution time for EMERGENCY Cases: _____ **Hours**

   Resolution time for Mental Health Cases: _____ **Hours**
   (EMERGENCY CASES)

   Resolution time for NON-EMERGENCY CASES: _____ **Calendar Days**

   Resolution time for Mental Health Cases: _____ **Calendar Days**
   (NON-EMERGENCY CASES)

6. **Describe any changes that have been made to your company's internal grievance procedures during the preceding year. (Attach copies).**